

about the nature of the two conditions, even the 75 percent accuracy is impressive.

ALEXANDER R. MARGULIS, MD

Department of Radiology
University of California School of Medicine
San Francisco

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"Prolixity Will be Construed as Uncertainty"

IN THE ERA of essay examinations, the warning, "Prolixity will be construed as uncertainty," was sounded before all of our anatomy examinations in our first year in medical school. The exhortation comes to mind now as we attempt to review the published reports on septic shock. Since the initial article on bacteremia due to enteric Gram-negative bacilli other than salmonellae came from the University of Minnesota in 1951,¹ there has been a major investigative effort to elucidate the pathophysiologic features and to develop rational and effective therapy for shock associated with bacteremia. Among the investigators, Doctors Weil and Shubin have been leaders, Doctor Weil's interest having been kindled in his early years at the University of Minnesota.

Interest in Gram-negative bacillary bacteremia has become widespread not only because of the recognition of the problem, but also because the frequency of such infections is increasing.² For example, at one university hospital where the average daily census is 300 patients, there are 200

cases of bacteremia due to Gram-negative bacilli annually, with a mortality of 34 percent.³ The frequency of Gram-negative bacillary bacteremia varies from hospital to hospital, but a prevalence of 0.8 percent of admissions is not uncommon. If this figure is projected to the 32,895,000 patients discharged from general hospitals in the United States in 1971, approximately 260,000 cases of Gram-negative bacillary bacteremia can be expected per year in the United States. The fatality rate varies between 20 and 50 percent. Assuming an average mortality midway between these values, 91,000 deaths per year may be attributed to Gram-negative bacillary bacteremia.

Against this background, the prevention and treatment of "Gram-negative" or "endotoxic" shock is a subject of major importance to all physicians. The review by Weil and Shubin which is published elsewhere in these pages summarizes current approaches to the treatment of patients with bacteremic shock which have been drawn from their careful and extensive physiological studies at the Shock Research Unit. All physicians should read this review. While the suggestions are not above controversy, Weil and Shubin have avoided being dogmatic, have emphasized the basic generalizations with which almost all clinicians agree, and have indicated the areas in which clear proof of therapeutic efficacy of a given regimen is lacking. The generalizations with which there is almost complete agreement include: sound surgical principles, such as draining of loculated pus, must be applied in the treatment of infections; early initiation of appropriate systemic antibacterial therapy is essential; and measures should be directed at the improvement of oxygenation at the cellular level. The fields of controversy include the value of corticosteroid drugs and of anticoagulation, vasopressor and vasodilator drugs.

However, as Weil and Shubin point out, even with modern tools of applied clinical physiology to correct circulatory collapse, the incidence and mortality of "Gram-negative" shock remain high. Emphasis must be directed at prevention, since many of these infections are acquired as a consequence of procedures which are considered by many physicians as minor, benign and routine, and as such are overlooked as important potential sources of Gram-negative bacillary bacteremia. Such procedures include the prolonged use of indwelling venous catheters, failure to employ properly closed urinary drainage systems, the use of ventilatory therapy equipment which has not been

decontaminated and the application of substances such as soaps, creams and ointments which may be contaminated with bacteria.

The length of these comments should not be construed as reflecting the breadth of the problem, but rather the continuing uncertainty about optimal methods for prevention and management of Gram-negative bacillary bacteremia. Perhaps with further clinical investigation, particularly in the areas of prevention through modification of the host^{4,5} or the environment, a future editorial may be as brief as "veni, vidi, vici."

JAY P. SANFORD, MD

Professor of Internal Medicine
University of Texas Southwestern Medical School
Dallas

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Informed Consent in Focus

THE LEGAL CONCEPT of "informed consent" has been thrust upon the medical profession rather precipitously and, for many physicians, without warning. To act and react intelligently and in the best interest of both patient and physician, several vital points need to be in focus.

1. "Informed consent" did not develop in a vacuum. For at least a decade in the United States and elsewhere the protection of the individual against the giants of mechanized and computerized society has been promoted, developed and imposed upon all. This protection, under the general label of "consumerism," manifests itself in many ways. Essentially, it is a revolt against mass advertising, mass production, mass distribution, mass everything. It has taken root and it is flowering. It has been said that consumerism is a magic word in contemporary society.

A basic concept of consumerism is that every individual has a "right to know" and a right to

make his own decision, uncoerced by television or any other overpowering, brain-washing technique. The legal doctrine of informed consent is one among hundreds of manifestations of the concept of the right to know and to make one's own decisions, good, bad or indifferent. To understand what the courts are saying on informed consent, one must relate the concept to the whole—the whole being protection of the individual.

2. While the legal requirement of informed consent in medicine is stated in terms of telling the patient about risks and alternates, there is nothing in the law or in the concept of informed consent that mandates presentation of a negative or fear-provoking approach to the patient. In *Cobbs vs. Grant* the California Supreme Court held that a legally valid consent requires that the physician convey all information necessary for the patient to make a knowledgeable decision. Although to date cases before courts have involved issues that have resulted in an emphasis on the negative aspects of the "tell it like it is" rule, the patient's right to know includes all essential information; in other words, the positive as well as the negative, the benefits as well as the risks. Therefore, in approaching application and implementation of informed consent on a real life physician-patient basis, it would appear essential for the physician to give equal billing to the benefits of a procedure—to the good that it may do and the reasons it is recommended.

3. There is nothing new in the requirement of consent to any procedure that involves bodily contact. Without consent, any bodily contact that involves possibility of harm is an assault or battery. Hence, consent, express or implied, has always been necessary to elective surgical procedures and to other procedures involving bodily contact. The newness is in the word "informed." The concept that the patient has a right to know, coupled with a right to make his own decision on the basis of knowledge, is the new development. This, however, changes traditional concepts. No longer does a printed form suffice. It neither implies nor proves that the signer had any information whatsoever. No longer can the task of obtaining consent be routinely delegated to aides and assistants. In *Cobbs vs. Grant* the California Supreme Court made it very clear that informing the patient is the duty of the physician. Consent without adequate information on which to form a judgment is no longer legally sufficient. The Court also said a patient may decline information. This is fine if